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	205091	A. BUILDING _____ B. WING _____	02/01/2024

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F 000	INITIAL COMMENTS From January 29, 2024 to February 1, 2024, on-site visits were conducted at Oak Grove Center for the purpose of completion of the annual Long Term Care Survey Process for Federal Recertification, and investigation of complaints and facility reported incidents: ME00046159, ME00046018, ME00044982, ME00044411, ME00044379, and ME00043939. It was determined that Oak Grove Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 3 of 3 Units (Jewett House, Millay House & Wyeth House) and the Laundry Findings: On 2/1/24, from 2:10 p.m. to 3:00 p.m., a surveyor did an environmental tour with the Interim Administrator, the Regional Maintenance Director, and the Housekeeper Supervisor in which the following findings were was observed: Jewett House > The resident Hoyer lift had chipped/missing paint on the legs creating uncleanable surfaces. > The resident sit-to-stand lift has dried food and dirt/debris in the foot base. >Resident Room #1 - The cove base was dirty	F 584		

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F 584	Continued From page 2	F 584		

and marred with black marks. The closet door, to the left and right of the sink was marred with black marks. The heater was marred with black marks. The floor around the base of the toilet was dirty. There was a commode bucket on the bathroom floor.
> Resident Room #4 - The cove base was dirty and marred with black marks. The closet door, to the left and right of the sink was marred with black marks. The heater was marred with black marks. There was debris in bathroom ceiling light.
> Resident Room #4 - The sink and bathroom were dirty and unclean.
> Resident Room #6 - The cove base was dirty and marred with black marks. The floor around the base of the toilet was dirty. The heater was marred with black marks. The closet door, to the left and right of the sink was marred with black marks. The sink and bathroom were dirty and unclean.
> Resident Room #9 - The cove base was dirty and marred with black marks. The closet door, to the left and right of the sink was marred with black marks. The heater was marred with black marks. The floor around the base of the toilet was dirty. There was a urinal hanging on the trash can.
> Resident Room #14 - The bathroom had a soiled, unlabeled urinal hanging on a wall faucet. unlabeled with yellow dried on it. The floor around the base of the toilet was dirty.
> Resident Room #15- The bathroom had an unmarked bed pan on the floor beside the toilet.
> Resident Room #18 - The bathroom had a soiled, unlabeled urinal resting on the trash can.

Millay House
> Resident Room #24- The cove base was dirty and marred with black marks. The floor around

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F 584	Continued From page 3 the base of the toilet was dirty. Wyeth House > The resident Hoyer lift had chipped/missing paint on the legs creating uncleanable surfaces. > The entire hallway had gaps in the flooring sections. > Resident Room #38 - There were bugs and debris in the bathroom ceiling light. The floor around the base of the toilet was dirty. He bathroom walls had chipped/missing paint and were marred with black marks. > Resident Room #39 - The floor around the base of the toilet was dirty. The bathroom floor had a black substance all over it. The bathroom walls were marred with black marks and had chipped/missing paint creating an uncleanable surface. The toilet seat and surrounding area behind the seat were dirty with debris and dried urine. The bathroom ceiling light had bugs and debris in it. > Resident Room #44 - There were several broken and dirty/stained floor tiles around the base of the toilet. > Resident Room #45 - The wall to the left of the bathroom door was marred with black marks and had chipped/missing paint creating an uncleanable surface. There were 3 floor tiles by the room entrance that had large gaps in them. > Resident Room #48 - The room floor entrance was missing the transition strip. The floor was dirty around the base of the toilet. There was a broken floor tile by the sink. Laundry > The cement floor between and behind the washing machines has chipped/missing paint creating uncleanable surfaces. > The floor was built up with dirt and dry chemical	F 584		

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F 584	Continued From page 4 residue. > The floor mat was ripped/torn and had edges that were raised and uneven. On 2/01/24 at 3:00 p.m., in an interview, the Interim Administrator, the Regional Maintenance Director and the Housekeeper Supervisor confirmed the findings.	F 584		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		

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F 625	Continued From page 5 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to issue a bed hold notice for a facility initiated transfer/discharge to a resident, or his/her legal representative, for 2 of 6 sampled residents transferred to an acute care facility (#191 #7). Finding: Documentation in Resident #191's clinical record indicated that he/she was transferred to an acute hospital and admitted on 1/23/24, and returned to the facility on 1/26/24. The clinical record lacked evidence that the facility issued a written bed hold policy/notice to the resident and/or legal representative for the transfer. On 1/30/24 at 3:45 p.m., in an interview with a surveyor, the facility's social worker confirmed that a bed hold notice was not provided at the time of transfer to the hospital. Documentation in Resident #7s clinical record indicated that he/she was transferred to an acute hospital and admitted on 1/11/24, and returned to the facility on 1/15/24. The clinical record lacked evidence that the facility issued a written bed hold policy/notice to the resident and/or legal	F 625		

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F 625	Continued From page 6 representative for the transfer. On 2/1/24 at 1:55 p.m., in an interview with a surveyor, the Marketing Clinical Advisor confirmed that a bed hold notice was not provided at the time of transfer to the hospital.	F 625		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 7 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 2 of 39 sampled residents (#22, #52). Finding: 1. Resident #22 was admitted to the facility on 12/29/23. A review of Resident #22's clinical record included a diagnoses of congestive heart failure, cardiomyopathy, diabetes, chronic kidney disease, prostate cancer with urinary retention which required an indwelling urinary catheter. Resident #22's baseline care plan, initiated 12/29/23 only addressed the resident's need for assistance with mobility. The interventions specified the need for the head of bed to be elevated, and physical and occupational therapy screens. No other information was provided.	F 655		

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F 655	Continued From page 8 On 1/3/24 and 1/4/24, the care plan was updated to address Resident #22's needs regarding activities of daily living, risk for cardiovascular complications, indwelling urinary catheter, risk of falls, diabetes, pain, medications, and indwelling urinary catheter. On 2/1/24 at 1:55 p.m., in an interview with a surveyor, the Marketing Clinical Advisor confirmed the baseline care plan did not accurately reflect Resident #22's care needs. 2. Resident #52 was admitted to the facility on 12/6/24 for skilled services from an acute care hospital with a diagnosis to include diabetes, seizure disorder, congestive heart failure and presence of a Gastrostomy tube (G-Tube). As of 1/31/24, Resident #52's clinical record lacked evidence of a baseline care plan and comprehensive care plan that included the instructions necessary to properly care for Resident #52's G-Tube. On 1/31/24 at 2:13 p.m. a surveyor confirmed that Resident #52's clinical record lacked evidence of a baseline care plan and comprehensive care plan that included the instructions necessary to properly care for Resident #52' G-Tube with the Marketing Clinical Advisor.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 9	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 10	F 656		

care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interviews, the facility failed to develop or implement the care plan interventions for the residents' current needs for residents requiring transmission-based precautions (TBPs) for 1 of 3 residents reviewed (#31).

Finding:

0n 1/30/24, a review of the clinical record revealed Resident #31 had a current physician order that noted: "contact precautions for urine only. staff should wear gloves with attends changes and goggles should splash from a bed pan or commode be possible. ESBL[Extended Spectrum Beta-Lactamase] in urine. Other Active 10/30/2023"

0n 1/30/24 at 2:00 p.m., a surveyor observed Resident #31's room and there was no personal protective equipment (PPE) station and no sign informing those entering the room that enhanced barrier precautions were required.

A review of Resident #31's current care plan did not include enhanced barrier precautions for Extended Spectrum Beta-Lactamase(ESBL).

0n 1/30/24 at 2:30 p.m., in an interview, the Director of Nursing and the Marketing Clinical Advisor confirmed that Resident #31 had ESBL and there should be an enhanced barrier precaution sign on the door and PPE available for staff use. Additionally, they both confirmed that the care plan did not include enhanced barrier

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F 656	Continued From page 11 precautions required for ESBL and that a urine culture had never been obtained to indicate the acute urinary tract infection for Resident #31 had been resolved.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide residents with a continuous resident centered activities program. This failure has the potential to affect all residents that would normally participate in activities. Findings: On 2/1/24 at 11:30 a.m., in an interview with a surveyor, Activities Staff stated no scheduled activities were provided on weekends since September/October of 2023, when the weekend activities staff position was eliminated. Staff stated if there is a special occasion, they will flex their weekday hours and work 1-2 hours on a weekend day for a special event. Otherwise, no group activities, including church services, are held on weekends. The Activities Staff stated they	F 679		

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F 679	Continued From page 12 set up recreation carts with self-directed activities available in the dining room of each unit. Staff stated there are no activities, other than tv, for residents who cannot participate independently. A review of the February 2024 Activities Calendar revealed the only weekend activity scheduled was a 2-hour Superbowl social on 2/11/24. On 2/1/24 at 11:45 a.m., the finding was discussed with the Marketing Clinical Advisor.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the residents environment was free from the potential risk of accidents relating to faux wood flooring for 1 of 3 units(Wyeth) for 1 of 1 observations. Findings: On 1/30/24 at 8:15 a.m., on the Wyeth Unit, a surveyor observed the faux wood flooring moving and coming up when carts were pushed down the hallway and staff were walking down the hallway. On 1/30/24 at 8:30 a.m., observations were made	F 689		

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F 689	Continued From page 13 on the Wyeth Unit by a surveyor, the Interim Administrator and the Regional Maintenance Director to observe the flooring. The Administrator confirmed that there were ambulating residents on the unit and that the loose and moving sections of flooring were not secured to the floor, were definitely an accident hazard for residents and staff. Both the Interim Administrator and the Regional Maintenance Director were able to pick different sections of the flooring up which were loose and not secured down. Further observation of the Wyeth Unit by a surveyor, the Interim Administrator and the Regional Maintenance Director revealed many sections of the flooring were loose, not secure to the floor and what looked like shrinking leaving gaps in the floor. On 1/30/24 at 8:30 a.m., in an interview, both the Interim Administrator and the Regional Maintenance Director confirmed this was an immediate accident hazard.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		

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preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to recognize and address a potential significant weight change for 1 of 8 sampled residents reviewed for nutritional status (#52).

Finding:

A review of the facility's policy for "Weights and Heights", stated "Patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Hospital weight will not serve as admission or re-admission weight.

A review of Resident #52's electronic clinical record indicated an admission date of 12/6/23. Resident #52's weight on 12/6/23 was recorded at 254 pounds. On 12/25/23, nineteen days later, Resident #52's weight was recorded at 224 pounds, revealing a potential 30-pound weight loss. Further review of Resident #52's clinical record lacked evidence of weekly weight monitoring for 12/13/23 and 12/20/23. There was no evidence staff followed up on Resident #52's potential 30-pound weight loss.

On 1/31/24 at 10:24 a.m., in an interview with a surveyor, the Center Executive Lead confirmed that staff did not follow the facility's policy by

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F 692	Continued From page 15 using the hospital weight as Resident #52's admission weight. In addition, the Center Executive Lead confirmed weekly weights for 12/13/23 and 12/20/23 were not obtained, and the facility failed to follow up on a significant weight loss for Resident #52.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident who requires dialysis receive such services, consistent with the professional standards of practice in the area of monitoring a dialysis catheter site from 10/4/2023 to 2/1/24, for 1 of 1 resident receiving dialysis (#69). Finding: On 2/1/24 at 11:15 a.m., during an interview with a surveyor, Resident #69 stated that he/she goes to dialysis on Monday, Wednesday, and Friday. The surveyor observed Resident #69 with a dressing to the left chest. Resident #69 stated that is what they use for dialysis right now but he/she will be getting a fistula soon. A review of Resident #69's clinical record revealed diagnoses which included, Congestive Heart Failure, Diabetes Mellitis, and Chronic	F 698		

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F 698	Continued From page 16 Kidney Disease, Stage 5. Documentation on Resident #69's hospital Discharge Documentation dated 10/2/23, indicated that on 9/28/23, Resident #69 had a placement of a tunneled dialysis catheter. A review of Resident #69's current care plan was completed. There is no mention that the resident has a tunneled dialysis catheter. There are no interventions for the care of the dialysis catheter or emergency care of the catheter. On 2/1/24 at approximately 11:00 a.m., the surveyor discussed the above findings with the Marketing Clinical Advisor.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		

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(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside on 3 of 3 units.

Findings:

1. On 1/30/24 at 10:39 a.m., in an interview with a surveyor, Resident #14 stated he/she had only had one bath since admission and was told he/she could have one per week. Resident #14 stated he/she had not received a shower, but had received one whirlpool bath and would like another.

A review of the Millay Unit's shower schedule showed that Resident #14's was scheduled to receive a shower or whirlpool bath on Wednesdays. A review of Resident #14's CNA (Certified Nursing Assistant) documentation for January, 2024, noted Resident #14 received a whirlpool bath only on 1/2/24 and 1/8/24. A review of CNA documentation for December, 2023, revealed Resident #14 refused showers on 3 days, however, multiple days were missing documentation of care provided.

2. On 1/30/24 at 10:11 a.m., in an interview a surveyor, Resident #29 stated he/she had

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received only one bath since being at the facility and would like to receive a bath at least once per week.

A review of the Millay Unit's shower schedule showed that Resident #29's room was scheduled to receive a shower or whirlpool bath on Tuesdays. A review of Resident #29's CNA documentation for January, 2024, showed Resident #29 received a whirlpool bath on 1/16/24 only. A review of CNA documentation for December, 2023, revealed Resident #29 received no showers or whirlpool baths during the month.

On 1/31/24 at 11:40 a.m., 3 surveyors discussed with the Corporate Market Clinical Advisor that residents were not receiving whirlpool baths or showers as scheduled, and confirmed documentation of care provided by direct care staff was missing.

3. On 1/31/24 at 11:40 a.m., in an interview with a surveyor, the Resident Council President stated call bells regularly take up to an hour to be answered, and if a resident has requested a snack or a drink, it takes an excessively long time to receive it.

A review of the Resident Council Minutes from July, 2023, through January, 2024, revealed the following concerns of the group:

1/17/24, "CNA staffing a concern. Would like 4 aides per unit during the day and two at night. Call bells not answered in a timely manner."

12/20/23, "Call bells being answered in a timely manner still a concern. CNA's responding to bells and saying they will return and not returning to

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F 725	Continued From page 19 assist resident." 11/15/23, "Call bells not being answered in a timely manner still a concern. No consistency with CNA's working the same units. CNA's walking past rooms with call bells on and not responding." 10/17/23, "Long Jewett (unit) not getting regular showers. Response to call bells still a concern." 9/12/23, "Residents being told things are taking too long because of staffing shortage." 8/16/23, "Showers not getting done regularly. Aides not always in dining rooms during meals. Aides working longer shifts are being ugly to residents." 7/19/23, "Residents are concerned with staffing issues. Call bells are not being answered ina timely manner." 4. On 1/29/24 at 11:31 a.m., during an interview with Resident #7. Surveyor asked "do you get the help you need without waiting a long time"? Resident #7 stated No, there's not enough staff. I've been going without baths and can't recall the last time I had a shower. A review of ADL documentation indicates that Resident #7's scheduled shower/tub day is every Wednesday. The Certified Nursing Assistant (CNA) documentation reviewed from October 2023, December 2023 to January 2024 indicated that Resident #7 did not receive scheduled showers on 10/18/23, 11/8/23, 11/22/23, 11/29/22, 12/6/23, 12/13/23, 12/20/23, 12/27/23, 1/3/24, 1/17/24 and 1/24/24.	F 725		

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5. Resident #27 was admitted to the facility on 12/7/23. A review of Activities of Daily Living (ADL) documentation indicate that Resident #27s scheduled shower/tub day is every Monday. The Certified Nursing Assistant (CNA) documentation reviewed from December 2023 to January 2024 indicated that Resident #27 did not receive scheduled showers on 12/11/23, 12/18/23, 12/25/23, 1/1/24, 1/8/24, 1/15/24, 1/22/24, and 1/29/24.

6. Resident #52 was admitted to the facility on 12/6/23. A review of ADL documentation indicates that Resident #52s scheduled shower/tub day is every Wednesday. The CNA documentation reviewed from December 2023 to January 2024 indicated that Resident #52 did not receive scheduled showers on 12/13/23, 12/20/23, 12/27/23, 1/3/24, 1/10/24, 1/17/24, and 1/31/24.

7. A review of ADL documentation indicates that Resident #69s scheduled shower/tub day is every Monday. The CNA documentation reviewed from October 2023 to January 2024 indicated that Resident #69 did not receive scheduled showers 10/2/23, 10/9/23, 10/16/23, 10/23/23, 10/30/23, 11/6/23, 11/13/23, 11/20/23, 11/27/23, 12/4/23, 12/11/23, 12/18/23, 12/25/23, 1/1/24, 1/8/24, 1/15/24, 1/22/24 and 1/29/24. Resident #69 received a shower on 10/10/23.

On 1/31/24 at 11:36 a.m. the above findings #4 to #7 were discussed with the Clinical Lead.

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8. On 1/30/24 at approximately 12:51 p.m., in an interview with a surveyor, Resident #55 indicated he gets a bed bath but does not get a shower or a whirlpool. A review of the shower schedule showed that Resident #55 was scheduled for showers or whirlpool baths on Tuesday evenings. A review of Resident #55's Certified Nurses Aid (CNA) documentation for October 2023 - January 2024 indicated he/she only received a shower on Tuesday, 10/17/23, Wednesday, 10/18/23 and Tuesday, 10/31/23.

9. On 1/29/24 at approximately 1:15 p.m., in an interview with a surveyor, Resident #79 indicated "I haven't received a shower or a whirlpool since I've been here." "There is not enough help, and as of today I was never offered a choice whether I wanted a shower or a whirlpool." Resident #79 was admitted on 11/23/23. A review of CNA documentation for November 11, 2023 - January 2024 indicated he/she only received bed baths.

10. On 1/29/24 at approximately 12:15 p.m., in an interview with a surveyor Resident #3 indicated that he/she does not receive his/her showers as requested for Fridays. A review of the shower schedule showed that Resident #3 was scheduled for showers or whirlpool baths on Fridays. A review of CNA documentation for October 2023 - January 2023 indicated that he/she only received a shower on Saturday 11/18/23, Tuesday, 11/28/23, and Saturday 1/20/24.

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F 725	Continued From page 22 11. On 1/29/24 at 4:12 p.m., in an interview with a surveyor, Resident #291's Power of Attorney (POA) indicated that the resident "did not receive showers because there wasn't enough staff." Further the POA indicated that Resident #291 was not given a choice whether he/she wanted a shower or a whirlpool. Resident #291 was admitted on 9/14/23 and discharged on 10/5/23. A review of CNA documentation for September 14, 2023 - October 5, 2023, indicated the shower schedule showed that he only received bed baths. On 2/1/24 at approximately 2:30 p.m., the findings #8 to #11 was discussed with the Corporate Market Clinical Advisor that residents were not receiving showers or whirlpool baths as scheduled and confirmed documentation of care provided by direct care staff was missing. Resident #32 was admitted to the facility on 12/14/15. A review of Activities of Daily Living (ADL) documentation indicate that Resident #32's scheduled shower/tub days are every Wednesday and Saturday. The Certified Nursing Assistant (CNA) documentation reviewed from December 2023 to January 2024 indicated that Resident #32 did not receive scheduled showers on 12/2/23, 12/6/23, 12/9/23, 12/16/23, 12/23/23, 12/27/23, 12/30/23, 1/6/24, 1/13/24, 1/24/24 and 1/27/24.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 730		

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F 730	Continued From page 23 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on performance evaluations and interviews, the facility failed to complete annual performance evaluations at least every 12 months for 3 of 5 sampled Certified Nursing Assistants (CNA #1, CNA #3, and CNA #5). Findings: 1. CNA #1 was hired on 12/20/21. CNA #1's last performance evaluation was completed in 2022. The facility was unable to provide evidence of a completed annual performance evaluation for 2023. 2. CNA #3 was hired on 6/29/21. CNA #3's last performance evaluation was completed in 2022. The facility was unable to provide evidence of a completed annual performance evaluation for 2023. 3. CNA #5 was hired on 4/4/16. CNA #5's last performance evaluation was completed in 2022. The facility was unable to provide evidence of a completed annual performance evaluation for 2023. On 2/01/24 at 8:25 a.m., in an interview, the Interim Administrator confirmed that the facility lacked documentation of 2023 yearly performance evaluations for CNAs #1, #3 and #5.	F 730		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 24 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, the facility's "Dish Machine Logs", "Food Storage-Cold Goods Policy and Procedure" last revised 4/2018, "Food Storage-Dry Goods Policy and Procedure" last revised 9/2017, and "Refrigerated/Frozen Storage Policy and Procedure" last revised 6/15/18, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for air conditioning units, vents, a mixer, the ice machine, shelving, a reach-in freezer, a walk-in refrigerator and dry storage for 1 of 1 kitchen tour. In addition, the facility failed to ensure that the dish machine was maintaining proper temperature ranges for proper cleaning and sanitizing. This has the potential to effect all residents. Findings:	F 812		

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The facility's Dish Machine Logs state at the bottom under Standards: high temp: wash: 150 to 160°F, rinse: 180°F. If temperature or chemical concentration does not meet parameters, stop washing and alert a manager or designee.

The facility's Food Storage: cold foods revised 4/2018 states under Procedures: 5. All foods will be stored wrapped in or covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

The facility's Food Storage: dry goods policy revised 9/2017 state under Procedures: 5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate.

The facility's Refrigerated/Frozen Storage policy states under Process: 1.4 All foods are labeled with the name of the product and date received and "used by" date once open. Manufacturer used by dates are used until opened. 1.5 Prepared foods are labeled and dated with the name of product, date open, and use by date.

On 1/29/24 from 9:15 a.m. to 9:40 a.m., an initial kitchen our was completed with the Acting Food Service Director in which the following findings were observed:
> There were 2 ceiling air conditioning units, 1 over the microwave and 1 over the stove, that were dusty/dirty.
> The ceiling vent by the stove was dirty and rusty.
> There was dried food residue on the mixer arms and base.
> The ice machine filter covers were heavily

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soiled with dust.
> The dish room wooden shelving had chipped/missing paint creating uncleanable surfaces
> Reach-in freezer #2 had a previously opened bad of cookie dough that was not labeled.
> The walk-in refrigerator had three, 16 ounce bags of whipped topping that had no thaw date. The product directions read good for 14 days once refrigerated/thawed. Additionally, there were 2 previously opened packages of cheese slices that were not labeled.
> The dry storage room had a previously opened package of saltine crackers that was not dated and labeled.

On 1/29/24 at 9:40 a.m., in an interview, the Acting Food Service Director confirmed the findings.

On 1/30/24 at 11:00 a.m., a surveyor reviewed and discussed the dish washer temperature logs with the Interim Administrator.
> The high temperature dish washing machine was unable to reach and maintain the wash cycle temperature of 150 degrees Fahrenheit and the rinse cycle temperature of 180 degrees Fahrenheit after numerus times running the machine.
The "Dish Machine Logs" revealed the following:
October 2023:
Dish machine temperatures not reaching 150° Fahrenheit for washing.
Breakfast - 1, 4, 5, 12, and 18.
Lunch - 1, 2, 5, and 8.
Dinner - 2, 3, 9, 15, 16, 17, 20, 21, 24-26,
Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing.
Breakfast - 2, 4, 5, 7, 8, 9, 12, 18, 19, 21, 23, 24,

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F 812	Continued From page 27 25 and 27-31. Lunch - 1, 4-6, 10, 11, 13, 14, 16, 23, 24 and 27-30. Dinner - 1-3, 9, 10, 13-18, 20, 21, 24-27, 29 and 30. November 2023: Dish machine temperatures not reaching 150° Fahrenheit for washing. Breakfast - 2, 4-7, Lunch - 2, 19, Dinner - 3, 9, 12, 14, 19, 22, 24-26 and 30. Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing. November 2023: Breakfast - 1, 2, 4, 7-14, 19, 20 and 27-29. Lunch - 2-4, 7-14, 18, 24, 25, Dinner - 2-4, 8, 12-14, 19, 21-25 and 27. December 2023: Dish machine temperatures not reaching 150° Fahrenheit for washing. Breakfast - 7, 12, 16, 18, 23, 26, 28 and 30. Lunch - 1, 2, 5, 10, 14, 16, 17, 20, 21, 25, 27 and 31. Dinner - 3, 5, 11, 13, 26 and 27. Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing. December 2023: Breakfast - 10, 12, 14, 16, 18, 23, 25 and 27. Lunch - 1, 5, 11, 14, 17, 26, 27, Dinner - 27 January 2024: Dish machine temperatures not reaching 150° Fahrenheit for washing. Breakfast - 11, Dinner - 1, 4-9, 12, 13, 15, 17, wasn't documented 20 and 21, 22, 23, wasn't	F 812		

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F 812	Continued From page 28 documented 24-26, 27, Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing. January 2024: Breakfast - 1-29 Lunch - 1, 2, 4, 6-8, 10, 12, 15, 17, 26 and 27. Dinner - 1, 3, 7, 8, 11-14, 16, wasn't documented 19-21, 22, 23, wasn't documented 24-26, 27 and 28. On 1/30/24 at 11:03 a.m., in an interview, the Interim Administrator confirmed that the dish washer temperatures were documented on some dates in 0ctober 2023, November 2023, December 2023 and January 2024 as to low for proper washing and rinsing/sanitizing of dishes and that some temperatures were not taken at all.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		

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F 842	Continued From page 29 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 12 of 39 residents reviewed for activities of daily living (#7, #14, #22, #27, #28, #29, #30, #32, #43, #52 & #69), and for 2 of 39 residents reviewed for medication and treatment administration (#14, #22).

Findings:

1. A review of Resident #7's Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for October 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

October 2023
Bed Mobility: 11 out of 31 days
Eating: 11 out of 31 days
Bathing: 11 out of 31 days

November 2023
Bathing: 20 out of 30 days

December 2023
Bathing: 24 out of 31 days
Eating: 21 out of 31 days

January 2024

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Bathing: 16 out of 29 days

2. Resident #14's clinical record revealed an admission date of 12/6/23. A review of Resident #14's CNA documentation of ADL's for December 2023 and January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

December 2023
Bathing - 21 out of 25 days
Bed Mobility - 21 out of 25 days
Dressing - 21 out of 25 days
Hygiene - 20 out of 25 days
Toileting - 21 out of 25 days
Transferring - 22 out of 25 days
Eating - 13 out of 25 days

January 2024
Bathing - 23 out of 31 days
Bed Mobility - 24 out of 31 days
Dressing - 23 out of 31 days
Hygiene - 23 out of 31 days
Toileting - 23 out of 31 days
Transferring - 24 out of 31 days
Eating - 16 out of 31 days

On 1/31/24 at 11:40 a.m., in an interview with 3 surveyors, the Marketing Clinical Advisor confirmed the above findings.

3. A review of Resident #14's Nursing Treatment Administration Record (TAR) documentation for January 2024, noted a lack of documentation for the following treatments:

- A provider's order, dated 12/21/23 "Right lateral heel/foot incision: clean with vashe, adaptic one layer over incision, cover with dry gauze. Wrap

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with bulky roll gauze, secure with tape." Documentation indicating the treatment was completed was lacking for 1/20/24 and 1/24/24.

- A provider's order, dated 12/14/23, "Tubigrips on in the a.m. and off in the p.m., every morning and at bedtime for edema." Documentation indicating the treatment was completed was lacking for 1/24/24 and 1/28/24.

- A provider's order, dated 12/7/23, "Voltaren gel 1%, apply to affected area topically two times a day for pain, 2 gram dose." Documentation indicating the treatment was completed was lacking for 1/24/24 and 1/28/24.

- A provider's order, dated 12/6/23, "Miconazole Nitrate Powder 2%, apply to affected area topically two times a day for skin. Documentation indicating the treatment was completed was lacking for 1/24/24.

- A provider's order, dated 12/29/23, "Left medial arch/foot: moisturize daily and apply sock." Documentation indicating the treatment was completed was lacking for 1/20/24, 1/24/24, and 1/28/24.

On 1/31/24 at 12:55 p.m., in an interview with the Marketing Clinical Advisor, a surveyor discussed the lack of documentation on Resident #14's TAR.

4. Review of Resident #22's clinical record revealed an admission date of 12/29/23. Diagnoses included Congestive Heart Failure and Cardiomyopathy. A review of provider orders revealed Resident #22 was treated with a diuretic for fluid overload. Resident #22 had an indwelling

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urinary catheter. A provider's order, dated 1/15/24, instructed nursing staff to record urinary output every shift.

A review of Resident #22's Medication and Treatment Administration Record (MAR/TAR) lacked documentation of urinary output as follows:

1/16/24 Night Shift
1/19/24 Night Shift
1/20/24 Day Shift
1/20/24 Night Shift
1/22/24 Day Shift
1/22/24 Night Shift
1/25/24 Day Shift
1/26/24 Night Shift
1/28/24 Night Shift

On 2/1/24 at 2:44 p.m., the finding was confirmed with the Marketing Clinical Advisor.

5. A review of Resident #27's CNA documentation of ADL's for December 2023 and January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

December 2023
Bathing: 19 out of 31 days

January 2024
Bathing: 18 out of 29 days

6. A review of Resident #28's Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for December 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:
December 2023

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Bed Mobility: 20 out of 31 days
Bathing: 20 out of 31 days
Bed Mobility: 20 out of 31 days
Hygiene - 20 out of 31 days
Toileting - 20 out of 31 days
Transferring - 18 out of 31 days

January 2024
Mobility: 15 out of 31 days
Bathing: 6 out of 9 days
Bed Mobility: 11 out of 31 days
Hygiene - 15 out of 31 days
Toileting - 17 out of 31 days
Transferring - 17 out of 31 days

7. A review of Resident #28's Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for December 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:
December 2023
Bed Mobility: 20 out of 31 days
Bathing: 20 out of 31 days
Bed Mobility: 20 out of 31 days
Hygiene - 20 out of 31 days
Toileting - 20 out of 31 days
Transferring - 18 out of 31 days
January 2024
Mobility: 15 out of 31 days
Bathing: 6 out of 9 days
Bed Mobility: 11 out of 31 days
Hygiene - 15 out of 31 days
Toileting - 17 out of 31 days
Transferring - 17 out of 31 days

8. Resident #29's clinical record revealed a readmission from the hospital on 1/8/24. A review of Resident #29's CNA documentation of ADL's for January 8-31, 2024, revealed multiple

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days lacking documentation on multiple shifts as follows:

Bathing - 21 out of 23 days
Bed Mobility - 21 out of 23 days
Dressing - 21 out of 23 days
Hygiene - 21 out of 23 days
Toileting - 21 out of 23 days
Transferring - 21 out of 23 days
Eating - 12 out of 23 days

On 1/31/24 at 11:40 a.m., in an interview with 3 surveyors, the Marketing Clinical Advisor confirmed the findings.

9. A review of Resident #30's CNA documentation of ADL's for October 2023 - January 2024 revealed multiple days lacking documentation on multiple shifts as follows:

October 2023
Bathing: 12 out of 31 days

November 2023
Bathing: 20 out of 30 days

December 2023
Bathing: 17 out of 31 days

January 2024
Bathing: 21 out of 29 days

10. A review of Resident #32's Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for December 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

December 2023

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Bed Mobility: 19 out of 31 days
Behavior Monitoring & Interventions: 19 out of 31 days
Eating: 18 out of 26 days
Bathing: 20 out of 31 days
Bed Mobility: 20 out of 31 days
Hygiene - 19 out of 31 days
Toileting - 16 out of 31 days
Transferring - 19 out of 31 days

January 2024
Bed Mobility: 15 out of 31 days
Behavior Monitoring & Interventions: 16 out of 31 days
Bathing: 16 out of 31 days
Bed Mobility: 16 out of 31 days
Hygiene - 17 out of 31 days
Toileting - 16 out of 31 days
Transferring - 16 out of 31 days

11. A review of Resident #43's CNA documentation of ADL's for October 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

October 2023
Bathing 14 out of 31 days
Bed Mobility: 12 out of 31 days
Eating: 12 out of 31 days

November 2023
Bathing: 20 out of 30 days

December 2023
Bathing: 22 out of 31 days

January 2024
Bathing: 17 out of 29 days

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12. A review of Resident #50's CNA documentation of ADL's for October 2023 - January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

October 2023
Bathing: 11 out of 31 days

November 2023
Bathing: 19 out of 30 days

December 2023
Eating: 18 out of 31
Bathing: 22 out of 31 days

January 2024
Bathing: 5 out of 29 days

13. A review of Resident #52's CNA documentation of ADL's for December 2023 January 2024, revealed multiple days lacking documentation on multiple shifts as follows:

December 2023
Bathing: 14 out of 31 days

January 2024
Bathing: 17 out of 29 days

14. A review of Resident #69's Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for October 2023 - January 2024. revealed multiple days lacking documentation on multiple shifts as follows:

October 2023
Bed Mobility: 19 out of 31 days
Bathing: 19 out of 31 days

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F 842	Continued From page 38 November 2023 Bathing: 23 out of 30 days December 2023 Bathing: 18 out of 31 days Eating: 16 out of 31 days January 2024 Bathing: 17 out of 29 days	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		

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F 880	Continued From page 39 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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Based on observations, interviews and record reviews, the facility failed to implement appropriate infection control standards for residents requiring transmission-based precautions (TBPs) for 3 of 3 residents reviewed (#31, #35, #198), and failed to ensure staff received appropriate education regarding TBPs.

1. 0n 1/30/24, a review of the clinical record revealed Resident #31 had a current physician order that noted: "contact precautions for urine only. staff should wear gloves with attends changes and goggles should splash from a bed pan or commode be possible. ESBL[Extended Spectrum Beta-Lactamase] in urine. Other Active 10/30/2023"

0n 1/30/24 at 2:00 p.m., a surveyor observed Resident #31's room and there was no personal protective equipment (PPE) station and no sign informing those entering the room that enhanced barrier precautions were required.

0n 1/30/24 at 2:30 p.m., in an interview, the Director of Nursing and the Marketing Clinical Advisor confirmed that Resident #31 had ESBL and there should be an enhanced barrier precaution sign on the door and PPE available for staff use.

0n 1/31/24 at 08:53 a.m., in an interview, the Marketing Clinical Lead confirmed that the only documentation of a urine culture shows the resident had ESBL and that a urine culture had never been obtained to indicate that enhanced barrier precautions were no longer needed for Resident #31.

2. On 1/29/24 at approximately 11:58 a.m., a

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F 880	Continued From page 41 surveyor observed outside of Resident #35's room, a personal protective equipment (PPE) station and a sign informing those entering the room that standard plus contact precautions were required. The surveyor observed CNA #1 enter the room of Resident #35 without donning PPE. CNA #1 then exited the room and a surveyor asked if he/she knew why Resident #35 was on precautions. CNA #1 stated that he/she was not aware that Resident #35 was on precautions stating that he/she did not receive report this morning. CNA #1 stated that he/she would ask the nurse. Within a few minutes CNA #1 returned and stated that Resident #35 was on precautions for E-coli in the urine. Surveyor showed CNA #1 the sign above the PPE cart that clearly stated Standard to Contact Precautions. CNA #1 stated that the sign is misleading and that he/she would only need to wear a gown and gloves when assisting the resident with toileting. CNA #1 then entered the room again without PPE. On 1/29/24 at 12:30 p.m. during an interview with the Clinical Marketing Lead, a surveyor discussed the discrepancy of signage outside residents room and that staff demonstrated a need for additional education regarding Enhanced Barrier Precautions. 3. On 1/30/24 at approximately 11:30 a.m., a surveyor observed outside of Resident #198's room, a personal protective equipment (PPE) station and a sign informing those entering the room that enhanced barrier precautions were	F 880		

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F 880	Continued From page 42 required. The surveyor asked LPN #1 why precautions were needed. LPN #1 searched Resident #198's electronic record and was unable to determine why the precautions were necessary. The LPN stated he/she would ask the nurse manager. Within a few minutes, LPN #1 returned and stated Resident #198 had ESBL (Extended Spectrum Beta Lactamase, a multidrug resistant organism) in his/her urine. On 1/30/24 at 11:40 a.m., a surveyor asked CNA#2 why Resident #198 required transmission-based precautions. The CNA stated Resident #198 had a virus in his/her urine, "something like you get if you eat raw chicken." A review of the clinical record revealed Resident #198 was admitted from an acute care hospital on 1/18/24 and was receiving treatment for acute cystitis. Urine culture results had confirmed the presence of ESBL and CRE (carbapenem-resistant Enterobacterales) Klebsiella, another multi-drug resistant organism. On 1/30/24 at 2:30 p.m., the surveyor discussed the observations and interviews with the Director of Nursing (DON). The DON confirmed further staff education regarding Enhanced Barrier Precautions was needed, as well as a more effective method to communicate a resident's need for TBP's to staff.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	F 908		

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F 908	Continued From page 43	F 908		

by:
Based on observations, interviews and he facility's Dish Machine Logs, the facility failed to ensure that the kitchen high temperature dish washing machine was maintained in good repair and in safe operating condition for 1 of 1 kitchen tours (1/29/24). From October 2023 to February 2024, the kitchen high temperature dish washing machine was no consistently reaching proper wash and rinse/sanitizing temperatures.

Findings:

The facility's Dish Machine Logs state at the bottom under Standards: high temp: wash: 150 to 160°F, rinse: 180°F. If temperature or chemical concentration does not meet parameters, stop washing and alert a manager or designee.

0n 1/29/24 between 9:15 a.m. to 9:40 a.m., during an initial kitchen tour, a surveyor asked dietary aides #1 and #2 please run the dish machine 3 times in a row. The first wash was 140 degrees Fahrenheit(F.) and the rinse was 160 degrees F. The second wash was 144 degrees F. and the rinse was 162 degrees F. The third wash was 144 degrees F. and the rinse was 160 degrees F. The surveyor asked dietary aide #1 and dietary aide #2 if they knew what the temperature is were for the high dishwashing machine for washing and rinsing. They both stated that they did not know what the proper wash temperature was for the dishwashing machine and that they would not know that when it was below 150 degrees Fahrenheit it should be reported to their supervisor and they should stop using it.

On 1/29/24 at 9:40 a.m., in an interview, the

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Acting Food Service Director confirm that the dish machine was not washing and rinsing slash sanitizing at the proper temperatures. Additionally, she stated that the dish machine had been acting up for many, many months and that an outside contractor has been in many times to work on it and try to fix it. She stated that bleach has been hooked up to the rinse cycle to help sanitize dishes because the dish machine will not always reach 180° Fahrenheit.

On 1/30/24 at 8:40 a.m., in an interview, the Regional Food Service Director and the Interim Administrator spoke to a surveyor about the dishwasher not washing and rinsing to temperature. The Regional Food Service Director stated that he had spoken with the facility's dish machine chemical company at 7:00 PM last evening and they assured him that the dish machine was hooked up to bleach and was sanitizing and working properly. The surveyor explained that the facility's dish machine was observed not washing at 150° degrees Fahrenheit that was also a problem. At this point, the Interim Administrator confirmed that the high temperature dishwashing machine was not washing and rinsing at proper temperatures and that this was an issue that needed to be rectified immediately. The Interim Administrator confirmed that the dish machine was not being used as of 1/29/24 when the problem was brought to their attention by the surveyor.

On 1/30/24 at 11:00 a.m., a surveyor reviewed and discussed the dish washer temperature logs with the Interim Administrator.
> The high temperature dish washing machine was unable to reach and maintain the wash cycle temperature of 150 degrees Fahrenheit and the

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rinse cycle temperature of 180 degrees Fahrenheit after numerus times running the machine.
The "Dish Machine Logs" revealed the following:
October 2023:
Dish machine temperatures not reaching 150° Fahrenheit for washing.
Breakfast - 1, 4, 5, 12, and 18.
Lunch - 1, 2, 5, and 8.
Dinner - 2, 3, 9, 15, 16, 17, 20, 21, 24-26,
Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing.
Breakfast - 2, 4, 5, 7, 8, 9, 12, 18, 19, 21, 23, 24, 25 and 27-31.
Lunch - 1, 4-6, 10, 11, 13, 14, 16, 23, 24 and 27-30.
Dinner - 1-3, 9, 10, 13-18, 20, 21, 24-27, 29 and 30.

November 2023:
Dish machine temperatures not reaching 150° Fahrenheit for washing.
Breakfast - 2, 4-7,
Lunch - 2, 19,
Dinner - 3, 9, 12, 14, 19, 22, 24-26 and 30.
Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing.
November 2023:
Breakfast - 1, 2, 4, 7-14, 19, 20 and 27-29.
Lunch - 2-4, 7-14, 18, 24, 25,
Dinner - 2-4, 8, 12-14, 19, 21-25 and 27.

December 2023:
Dish machine temperatures not reaching 150° Fahrenheit for washing.
Breakfast - 7, 12, 16, 18, 23, 26, 28 and 30.
Lunch - 1, 2, 5, 10, 14, 16, 17, 20, 21, 25, 27 and 31.
Dinner - 3, 5, 11, 13, 26 and 27.

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F 908	Continued From page 46 Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing. December 2023: Breakfast - 10, 12, 14, 16, 18, 23, 25 and 27. Lunch - 1, 5, 11, 14, 17, 26, 27, Dinner - 27 January 2024: Dish machine temperatures not reaching 150° Fahrenheit for washing. Breakfast - 11, Dinner - 1, 4-9, 12, 13, 15, 17, wasn't documented 20 and 21, 22, 23, wasn't documented 24-26, 27, Dish machine temperatures not reaching 180° Fahrenheit for rinsing/sanitizing. January 2024: Breakfast - 1-29 Lunch - 1, 2, 4, 6-8, 10, 12, 15, 17, 26 and 27. Dinner - 1, 3, 7, 8, 11-14, 16, wasn't documented 19-21, 22, 23, wasn't documented 24-26, 27 and 28. On 1/30/24 at 11:03 a.m., in an interview, the Interim Administrator confirmed that the dish washer temperatures were documented on some dates in 0ctober 2023, November 2023, December 2023 and January 2024 as to low for proper washing and rinsing/sanitizing of dishes and that some temperatures were not taken at all. On 2/1/24 at 10:00 a.m., in an interview, the Regional Maintenance Director informed a surveyor that a contractor had been in the evening before and found a problem with a hot water valve supplying hot water to the dish machine. Apparently, there was a stuck valve and it needed to be fixed and or replaced. The	F 908		

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F 908	Continued From page 47 Regional Maintenance Director stated that this was some of the problem with the dishwasher but not the total problem. He stated that the dish machine had been hooked up to bleach because the water booster would not consistently heat the water above 180° F. The Regional Maintenance Director informed the surveyor that the dish machine had been worked on many times in the past and it appeared that it needs a new water booster.	F 908		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum,	F 947		

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F 947	Continued From page 48 training on abuse, resident rights and dementia management by failing to ensure that 1 of 5 Certified Nursing Assistant's (CNA) employed, completed the required annual training (CNA #1). Findings: On 1/31/24, during a review of employee personnel records, the following was noted: 1. CNA #1's employee personnel record lacks evidence of mandatory abuse, resident rights and dementia training within the last twelve months. On 1/31/24 at 1:15 p.m., during an interview with a surveyor, the Marketing Clinical Advisor confirmed that there was no facility documentation to show that CNA #1 received the mandatory abuse, resident rights and dementia training within the last twelve months.	F 947		